TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TX Health DBA Injury 1 of Dallas FW

Respondent Name
Arch Insurance Company

MFDR Tracking Number
M4-16-2005-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 16, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient was approved for the Work Hardening Program. The services were provided and the claims were paid to the wrong provider."

Amount in Dispute: $2240.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Division Note: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged as received on March 24, 2016. 28 Texas Administrative Code §133.307(d)(1) requires that:

> The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

The insurance carrier did not submit a response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 21, 2015 – September 9, 2015	Work Hardening	$2240.00	$2240.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of medical bills.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
4. The submitted documentation did not include explanations of benefits for the services in question.

Issues

1. What is the maximum allowable reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to reimbursement for the services in question?

Findings

1. 28 Texas Administrative Code §134.204(h) states,

   > The following shall be applied to … Work Hardening/Comprehensive Occupational Rehabilitation Programs …
   > (1) Accreditation by the CARF is recommended, but not required.
   > (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR.

   28 Texas Administrative Code §134.204(h) further states,

   > (3) For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.
   > (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.
   > (B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes.

   For date of service August 21, 2015, the MAR for procedure code 97545-WH-CA, 1 unit, is $128.00. The MAR for procedure code 97546-WH-CA, 5 units, is $320.00. Submitted documentation supports these services.

   For date of service August 31, 2015, the MAR for procedure code 97545-WH-CA, 1 unit, is $128.00. The MAR for procedure code 97546-WH-CA, 5 units, is $320.00. Submitted documentation supports these services.

   For date of service September 2, 2015, the MAR for procedure code 97545-WH-CA is $128.00. The MAR for procedure code 97546-WH-CA, 5 units, is $320.00. Submitted documentation supports these services.

   For date of service September 8, 2015, the MAR for procedure code 97545-WH-CA is $128.00. The MAR for procedure code 97546-WH-CA, 5 units, is $320.00. Submitted documentation supports these services.

   For date of service September 9, 2015, the MAR for procedure code 97545-WH-CA is $128.00. The MAR for procedure code 97546-WH-CA, 5 units, is $320.00. Submitted documentation supports these services.

2. Submitted documentation finds that the insurance carrier did not reimburse or deny payment to the billing provider in accordance with 28 Texas Administrative Code §133.240. Therefore, the division finds that the requestor is eligible for reimbursement of the disputed services. The total MAR for the disputed services is $2240.00. This is the recommended amount.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2240.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2240.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	May 25, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.